UNITED CONCORDIA

APPLICATION FOR GROUP DENTAL INSURANCE

APPLICANT'S LEGAL NAME AND ADDRESS:

Name

Address

NATURE OF BUSINESS: | **INDUSTRY SIC CODE:**

Is Applicant exempt from ERISA? Yes ☐ No ☐

For general correspondence, receipt of billings and certificates:
(If address is different than noted, place contact address on back)

Policymaker Name: _____
Title: _____
Phone: _____ Fax: _____
Email: _____

Group Administrator: _____
Phone: _____ Fax: _____
Email: _____

FFS PRODUCTS: **FLEX:** ☐ **PREFERRED:** ☐ **SELECT:** ☐ **CHOICE:** ☐ **OTHER:**

STANDARD OPTION: _____ _____ _____ _____ _____

	IN	OUT	STEP PLANS
Program Deductible: (Ind./Family)	$___/____	$___/____	$____/____
Deductible Max Period: Contract Year ☐ Calendar Year ☐ Lifetime ☐			
Deductible Applied to all Services: Yes ☐ No ☐			
If No, Services Exempt from Deductible: Class I ☐ Class II ☐ Class III ☐ Ortho ☐			
Program Max: Yr ☐ Lifetime ☐	$_____	$_____	$_____
Ortho Max: Yr ☐ Lifetime ☐	$_____	$_____	$_____
Waiting Periods (Mos.): Class I _____ Class II _____ Class III _____ Ortho _____			

FFS NETWORK REIMBURSEMENT:
Advantage ☐ Advantage Plus ☐
National FFS ☐ No Network ☐
Access ☐
Pricing -- In _____/Out _____

DENTAL PREPAID PRODUCT:
PLUS/Third Column: ☐
Standard Plan_____
Non-Standard Plan: attach detail

PREMIUM PAYMENT PERIOD:

Monthly ☐ Semi-Annually ☐
Quarterly ☐ Annually ☐

Premium must be paid in advance.
Checks payable to United Concordia.

GROUP EFFECTIVE DATE:

(1st of month) ____/____/____

PRIOR COVERAGE: Yes ☐ No ☐

Carrier _____

RATES:

Certificate Holder: _____
Certificate Holder & One Adult: _____
Certificate Holder & One Child: _____
Certificate Holder & Children: _____
Certificate Holder & Family: _____

PARTICIPATION SUMMARY:

_____ # Eligible employees
_____ # Enrolled
_____ # Waived
_____ # Spouse Opt-Outs

DEPENDENT COVERAGE INCLUDES:

Spouse ☐
Children ☐
Non-Students to Age _____
Students to Age _____
Domestic Partners ☐

RATE PERIOD: (MM/DD/YYYY)

From _____ 12:01 AM
(1st of month)
To _____ 12:00 AM
(Last day of month)

ELIGIBILITY WAITING PERIOD: New Certificate Holders are eligible for coverage on the _____ of the month following _____ days/mos in an eligible class, or other: _____.

THE APPLICANT REPRESENTS that: by signing this application, he/she agrees that the group dental insurance described above will become effective upon acceptance of this application by United Concordia (UC). Applicant further acknowledges that no coverage will be effective before the date determined by UC and only if the first Premium has been paid and underwriting bid qualifications are met. If this application is accepted, it becomes a part of the insurance contract between Applicant and UC. If this application is not accepted, any Premium advanced by the Applicant will be refunded. Applicant warrants that all information on this application is true and complete, and acknowledges that coverage may be rescinded if there are material misstatements on this application. If errors or omissions in this application are discovered by UC, it is authorized to amend this application by noting the changes on this form, and the acceptance, evidenced by Premium payment, of any Policy issued on this application, so amended, shall constitute a ratification of any such changes or amendments. Upon policy renewal date, payment of the renewal premium will confirm acceptance of that renewal for the subsequent rate period. No agent or broker has the right to accept this application or bind coverage. Any first premium or application submitted to UC or its sales personnel by a non-appointed producer must be accompanied by completed appointment paperwork or it will be returned to the non-appointed producer. **Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime.**

By: _____ (Date) Producer: _____ SSN#: _____

Title: _____ Agency: _____ Tax ID: _____

Dated at: _____ (City) (State) UC Producer ID#: Agency_____ Producer _____

State Law Provisions

CA:	California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.
FL:	Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.
AZ, GA, KY, NE & NH:	All statements made by the Policyholder or by any insured Member shall be deemed representations and not warranties, and no statements made for the purpose of effecting coverage shall void such coverage or reduce benefits unless contained in writing and signed by the Policyholder.
KS:	Any person who knowingly and with intent to defraud, as stated on this Application, maybe committing a fraudulent insurance act which maybe a crime.
LA:	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and maybe subject to fines and confinement in prison.
IN, MO & ND:	All statements made by the Policyholder or by the persons insured shall be deemed representations and not warranties and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative.
NJ:	All statements made by applicant are true and complete to the best of the applicant's knowledge and belief. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
NY:	Any person who knowingly and with intent to defraud, as stated on this Application, shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
OR:	Any person who knowingly and with intent to defraud, as stated on this Application, maybe committing a fraudulent insurance act which maybe a crime. Contestability is limited to two years as stated in the Group Policy.
TN:	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
VA:	Any person who within the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

United Concordia programs are underwritten by the following companies in the listed states:

United Concordia Dental Corporation of Alabama - AL
United Concordia Dental Plans, Inc. - MD, NJ
United Concordia Dental Plans of California, Inc. - CA
United Concordia Dental Plans of Delaware, Inc. - DE
United Concordia Dental Plans of Florida, Inc. - FL
United Concordia Dental Plans of Kentucky, Inc. - KY
United Concordia Dental Plans of the Midwest, Inc. - MI, MO, OH
United Concordia Dental Plans of Pennsylvania, Inc. - PA
United Concordia Dental Plans of Texas, Inc. - TX
United Concordia Insurance Company - AK, AR, AZ, CA, CO, CT, FL, GA, IA, ID, IN, KS LA, MA, MD, ME, MI, MN, MS, MT, NE, NV, NH, NM, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WI, WV, WY
United Concordia Life and Health Insurance Company - DE, DC, IL, KY, MD, MO, NC, NJ, PA
United Concordia Insurance Company of New York - NY

Products not available in any state where prohibited by law or where United Concordia does not have regulatory approval.

UNITED CONCORDIA

Paperwork submitted by:

Name:_____

Phone number:_____

E-mail address: _____

Please indicate (yes or no) if a broker was involved in this transaction: _____

If yes, please provide the following applicable information.

General Agent: _____

Agency: _____

Producing Agent: _____